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Ethical Issues Associated With Secondary Trauma in Therapists

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James F. Munroe's systematic paper reexamines one of the oldest ethical guidelines in the field, that of the American Psychological Association, in the light of Secondary Traumatic Stress. For many years, we have concentrated exclusively on protecting the client with little or no regard to the caregiver. However, time has shown us that impaired caregivers are not only a loss to the professional community, they are potentially dangerous. This chapter shifts the perspective from being patient-centered to being helper-centered. This is not to reducee the importance of being patient-centered, but to acknowledge the importance of the mental health of the caregiver in his or her ability to give care and to live a productive life.

In recent years, increasing attention has been paid to the effects of trauma therapy on therapists and other professionals who provide care. The trauma literature contains several anecdotal references to therapists suffering such effects as sharing the nightmares of the survivors they were treating (Danieli, 1984; Langer 1987), sharing the hopelessness of clients (Mollica, 1988), having feelings of aggression (Scurfield, 1985), con-

fronting one's own vulnerability and moral attitudes (Haley, 1985), or having feelings of numbing and avoidance (McCann & Pearlman, 1990). Danieli (1984; 1988) proposed that the therapists of survivors of the Holocaust enter into a conspiracy of silence in which the impact of the Holocaust is denied. Herman (1988; 1992) identified the symptoms of incest survivors as being contagious for the therapists who treat them. McCann and Pearlman (1990) referred to such responses as vicarious traumatization and suggested that the effects of trauma therapy on therapists were likely to influence the therapists' personal lives as well as their ability to do therapy. Others have described the effects on therapists as secondary trauma (Catherall, 1992; Figley, 1988; Rosenheck & Nathan, 1985) and more recently a volume by Figley (1995) has identified these effects as compassion fatigue. The common thread among these conceptualizations is that those who do therapy with trauma survivors begin to experience responses that parallel those of their clients.

Secondary effects have long been noted in family members of trauma survivors (Danieli, 1988; Figley, 1988; Milgram, 1990; Nagata, 1990; Solomon, 1990). Empirical studies have demonstrated mixed results on second generation effects, but methodological differences have made it difficult to compare results (Ancharoff, 1994). What does seem to emerge is that although the secondary effects in family members may not reach diagnostic levels, there are still indirect effects from trauma. More recently, several authors have studied these effects more systematically in therapists. Munroe (1991) studied therapists working with combat veterans and found that increasing exposure to PTSD clients was significantly related to higher scores on intrusion and avoidance, and that these effects were distinct from burnout. Kassam-Adams (1995) similarly found higher levels of intrusion and avoidance related to increased therapist exposure to sexually traumatized clients. Chrestman (1994) found that exposure to trauma clients was significantly associated with increased intrusion, avoidance, dissociation, and sleep

disturbance in therapists. The overall finding in these studies is that therapists are affected by the trauma work they do and the effects of this work parallel the symptoms of the trauma clients. This raises the question as to whether doing trauma therapy is traumatic in itself. DSM-IV (APA, 1994) criteria for PTSD include being confronted by events that happen to others and experiencing helplessness as a result, as traumatic. Increasingly it appears that the question is not whether therapists will be exposed, but rather, how they will deal with the inevitable results of exposure. If trauma therapy is producing trauma responses in therapists, many substantial ethical questions are raised as to the welfare of therapists and the clients they treat.

The ethical issues in this chapter will draw on the ethical codes for psychologists published by the American Psychological Association (1992); however, ethical codes from other professional organizations reflect similar issues. Where the term "psychologist" is used here, the reader should feel free to substitute appropriate terms, such as therapist, social worker, case manager, counselor, researcher, psychiatrist, administrator, or others who work with trauma survivors. This chapter will not attempt to answer the variety of questions that arise, but seeks mainly to illustrate some of the issues which will have to be dealt with.

The Duty to Warn

If therapists who work with trauma survivors are susceptible to suffering effects from their exposure, we must raise the question of a duty to warn. We are required to warn people if there is an immediate danger, such as a threat to a specific person by a client or when an abusive situation involves children. Since we have reason to believe that harm could come to a therapist as a result of the trauma work they do, this imposes a responsibility to at least warn them of potential damage. A seemingly appropriate time to issue the warning would be when hiring or as-

signing a new therapist to work with trauma clients (see Figure 1). We may not be able to tell, however, which clients have trauma histories. Perry, Herman, van der Kolk, & Hoke (1990) found that many clients diagnosed as borderline may have undetected trauma histories. Clients who present with substance abuse problems may also be unidentified trauma survivors. It is possible that many clients have significant trauma histories that are not revealed. Munroe, Shay, Fisher, Makary, Rapperport & Zimering (1995) have suggested that transmission of secondary trauma can occur without the content of the trauma being revealed. This indicates that we would be unable to predict which clients would have an effect on therapists, and therefore, it would seem reasonable to warn therapists before they begin working with any clients.

There is also no reason to assume that therapists in the field are sufficiently aware of the danger. Munroe (1991) found that age and experience did not act as a buffer for secondary effects, but that the influence of education level may have been somewhat protective. Kassam-Adams (1995) found that experience and education did not buffer secondary effects. Chrestman (1994) found years of professional experience and higher income were related to fewer effects, but in each of these studies, none of the subjects appeared immune from the effects. It is also possible that some experienced therapists avoid trauma clients and studies which measure secondary trauma, because they serve as reminders of their exposure. It has not been demonstrated that experience or education can prevent secondary effects. Further, we do not know what specific components of education or experience might provide buffering. It might be tempting, and somewhat self protective, to assume that experienced therapists are not susceptible, but there is insufficient data to back up this assumption. The question of cumulative effects, or inoculation effects, is unanswered in primary trauma and as yet unquestioned in secondary trauma. Given this, it again seems prudent to warn all therapists.

FIGURE 1. Proposed Informed Consent Form for Trauma Therapists.

I, _____, have been informed by the staff at _____, that this program works with survivors of trauma, and that I therefore will inevitably be exposed to the effects of secondary trauma. I have been informed that these effects can have beneficial or detrimental results; if dealt with openly, such responses can be viewed as parallels to the clients' trauma responses and as such, are valuable clinical information; if denied or ignored, these same responses can lead to an altered world view which may impede my clinical judgment and interfere with my personal life. I have been informed that my age, experience, or professional training may not provide adequate protection from secondary trauma. I have been informed that the staff expects each member, including myself, to work to understand and act on how this work affects each staff member in the delivery of services to our clients. I have been informed that I may not be a good observer of how this process affects me at any given time. I have been informed that the staff believes all of its actions and interactions related to secondary trauma are considered models for our clients and that each member of the staff is expected to recognize an ethical obligation to model good self care.

_____ _____

Signature Date

DUTY TO TRAIN

The APA guidelines, under "design of education and training programs," state that such programs should "seek to insure that programs are competently designed, provide for proper experiences" (p. 1607). This suggests that not only should we be concerned about warning candidates of the potential harm of being exposed to trauma, but that we should also train them how to cope with this exposure. We cannot be content to train psychologists who expect to do therapy, but must consider re-

searchers, non-psychologists, and others who will be exposed. Many fields have begun to respond to the exposure of workers to secondary trauma (Gersons, 1989; McCammon, Durham, Allison, & Williamson, 1988; McCammon & Allison, 1995; McFarland, 1986; Talbot 1990). Should course work be required in training programs? Should accrediting bodies require programs to provide such training?

The duty to train does not end with educational or preparatory programs. As with primary trauma, we can expect parallel numbing and denial to show up in secondary trauma. Training students and sending them out into a professional world which denies the effects of secondary trauma will not be very helpful. Is there a duty to train those already in the field? Should employers, administrators, and professional organizations require continuing education on secondary effects?

Occupational Hazard

Secondary traumatic exposure for therapists and other professionals is part of their job responsibilities. Therapists who have been warned should also be instructed on the importance of balancing their professional and personal lives. Yassen (1995) has pointed out the importance of healthy practices for trauma therapists, and this should be included in training programs. It is not sufficient for employers, however, to instruct therapists to take care of themselves off the job; active preventive measures should also be a regular part of the work environment. Chrestman (1994) found that smaller caseloads and varied assignments reduced exposure. If work is dangerous, employers should strive to provide safe working conditions and reduce risk. An important part of providing such conditions is to work to overcome denial and numbing. If the work environment is not active in this, there is likely to be victim blaming. Those who begin to show signs of being affected will be identified as poorly trained, unable to do the job, or personally flawed. A work environment

that denies the existence of these problms will not only prevent such a worker from getting needed support, but will silence other workers, and likely decrease efficiency and effectiveness. If workers are referred out to an employee assistance program (EAP) it may also decrease the likelihood of others responding openly to avoid being stigmatized. Regular debriefing sessions can be helpful, but if these become mandatory, they may defeat the purpose of creating a safe environment for therapists to talk about effects. It may be necessary to have an active ongoing struggle to deal with secondary effects rather than a set plan.

Welfare of the Client

Under "concern for others' welfare" the APA ethical code states, "psychologists seek to contribute to the welfare of those with whom they interact professionally" (p. 1600), and under "social responsibility" states "psychologists are aware of their professional and scientific responsibilities to the community and the society in which they work and live" (p. 1600). If the therapist is being influenced by secondary effects this code may be violated.

Secondary effects will parallel primary symptoms. A therapist who is overwhelmed by the traumatic impact of numerous clients may be in a state of avoidance when a particular client comes in. It is possible that when this client needs to talk about trauma, the therapist will discourage discussion to protect him- or herself. Alternately, the therapist who is in an intrusive phase may insist on getting at the details of a client's trauma when the client is not ready. If the therapist is suffering from disturbed sleep or nightmares he or she may not be attentive to the needs of the client. The therapist's irritability from overexposure may result in the client's being silenced during a session. Overexposed therapists may also be trying to rescue clients who do not need to be rescued, or going on a mission to route out traumatic perpetrators when this is not in the client's best in-

terest. Therapists might also become suspicious of other professionals whom they think do not "understand" the needs of trauma clients, and thereby impede the client from accessing necessary services. Therapists may begin to avoid their trauma clients and misdiagnose them, or they may avoid meetings and supervision. In short, the clients' welfare may be compromised unless professionals recognize the needs of the therapist.

MULTIPLE RELATIONSHIPS

When therapists are overloaded with their clients' traumatic histories and suffering from the effects, it may be obvious to clients before professionals take notice. Many clients are acutely aware of, or concerned about the effects of trauma on others, including therapists (Munroe, Makary & Rapperport, 1990). They see it when they try to talk to family or friends and they know the effects on themselves. Often in therapy clients will comment that they cannot tell their spouses, parents, children, or other therapists about what happened to them because they do not want to harm these people. They will give accounts of how a certain therapist or professional reacted to their stories. Such stories may not be aimed at the people they talk about, but are rather a question to the current therapist about whether he or she will be harmed by the same stories. Therapists will often respond to the story rather than the question. If the client is indeed asking such a question and the therapist does not respond to it, the client may assume that the therapist cannot listen to the trauma material and be unharmed. When the client begins to protect the therapist from the harmful effects of trauma stories, the roles have been switched. The client is now taking care of the therapist, and the therapist has become both therapist and client. This constitutes a dual relationship and an ethical violation. The APA code indicates that a therapist should not be in a relationship if "such a relationship reasonably might impair the psychologist's objectivity or otherwise interfere with

the psychologist's effectively performing his or her functions as a psychologist, or might harm or exploit the other party" (p. 1601). If the client has to protect the therapist, it would seem this is both an impairment and an exploitation on the part of the therapist. Additionally, the implied message the therapist is acting out is that trauma should be denied and avoided. This seems hardly an appropriate message for a client who has come for help with traumatic experiences.

The APA code also states, "psychologists are sensitive to real and ascribed differences in power between themselves and others, and they do not exploit or mislead other people during or after professional relationships" (p. 1600). Clients may not ask the implied question of whether the therapist will be affected because of the real or ascribed power differential. A direct question of the therapist may often be countered with an interpretation of the client's questioning behavior rather than a direct response. There is clearly a power differential in who gets to ask questions regarding the other's internal states. When therapists fail to address the issue, whether overt or implied, they may be misleading their clients. The therapist may also be sending a message of superiority, thereby distancing from the client. When therapists imply that they are not affected by the client's trauma story, the client may also assume the therapist is stating that he or she would not have been affected by the same experience. This suggests that the client is somehow defective and unable to handle situations as the therapist would. This may be exactly what the therapist would like to think. The question as to whether the therapist would have handled the trauma any better is a direct confrontation of the therapists' sense of invulnerability. If the therapist cannot face the question of vulnerability to traumatic experiences, the client may well wonder whether the therapist can be of any help. If the therapist cannot handle questions of his or her own vulnerability, is not the client placed in a dual relationship?

The APA codes also state that "psychologists make reasonable efforts to answer patient's questions and to avoid apparent misunderstandings about therapy" (p. 1605). The question about effects on therapists, even if silenced by power differentials, seems to be one that needs to be answered. Therapists are advised about "avoiding harm" and it seems reasonable for the client to be concerned with the same issue. The code in this section also states that "psychologists discuss with clients or patients as early as is feasible in the therapeutic relationship appropriate issues" (p. 1605). If the issue of therapist vulnerability will determine the client's ability to utilize services, this is an appropriate issue to discuss whether the therapist is comfortable with it or not.

Should the therapist bring up the issue at the beginning of therapy even if the client does not ask? If the therapist does so, it would diminish the impression of superiority by acknowledging that trauma can affect anybody, including therapists. The therapist should then be able to inform the client as to how she or he and their professional colleagues go about protecting and supporting themselves. This would not only relieve the client of the responsibility of caring for the therapist, but would also model methods for coping with trauma, such as a regular consultation with a team to discuss therapist reactions. It could be argued that such a discussion might place an unnecessary burden on a client who might not even be concerned with this issue. It can also be argued that clients may not ask even if they are concerned, and it is therefore the therapist's ethical duty to address the question. Others may argue that putting the therapist in a vulnerable light might be detrimental to clients who need a strong expert image to rely on. It can also be argued that such an invulnerable image is an inappropriate model for clients

to look up to. But again, this may be encouraging denial and numbing.

Informed Consent

The codes state that clients are "informed of significant information concerning the procedure" (p. 1605). The possibility that a therapist's effectiveness may be diminished by the effects of secondary trauma certainly seems significant to clients. Further, it seems significant to inform the client that therapists have adequate resources to deal with such effects. We must also ask ourselves, what if the client already knows or suspects, and we do not address the issue? Clients are frequently concerned about the same effects on their families. Numerous authors have addressed the issue of inter-generational transmission of trauma (Ancharoff, 1994; Danieli, 1984, 1985, 1988; Figley, 1985; Harkness, 1993). A genuine discussion of therapist coping may validate the client's concerns and provide some effective strategies for helping families members cope. Such a discussion necessitates that therapists develop adequate coping strategies for themselves.

Privacy and Confidentiality

The codes state that psychologists "discuss the relevant limitations on confidentiality...and the foreseeable uses of the information generated" (p. 1606). Therapists might be very comfortable informing a client that case material will be presented for purposes of diagnosis or treatment planning, but should such a discussion also include the use of case information to assess therapist responses? Again, this would relieve the client of having to care for the therapist and provide a healthy model for coping with trauma. Such consultations would actually deal more with therapist responses and would require no more client

information than a more traditional case presentation. The codes do not require that information should not be shared, but only that the limitations be explained. Informing the client might be very reassuring. Too much privacy around trauma stories might also reinforce the client's belief that nobody wants to hear what happened. A therapist who does not share trauma stories and their own responses may be seen as colluding in another conspiracy of silence (Danieli, 1984). Confidentiality can be confused with secrecy. Confidentiality can reside in a team of professionals as well as an individual, as long as the client is informed.

Personal Problems and Conflicts

The APA codes specify that psychologists "refrain from undertaking an activity when they know or should know that their personal problems are likely to lead to harm....[They] have an obligation to be alert to signs of, and to obtain assistance for, their personal problems at an early stage, in order to prevent significantly impaired performance" (p. 1601). If the therapist knows of a problem that influences therapy, he or she has a choice of what to do, but if a therapist "should know," but does not know, there is a problem. It is entirely possible that when a therapist is being secondarily traumatized, denial becomes a way to cope. If the therapist is in denial then he or she may not know there is a problem even though each therapist should know. There is also the problem of determining when the effects of secondary trauma lead to the therapist becoming "significantly impaired." Is a therapist who is preventing clients from talking about their traumas because of his or her own feelings of being overwhelmed significantly impaired? Is the therapist who is beginning to share the world view of a number of trauma clients able to recognize when he or she is becoming impaired?

The Engagement-transmission model of secondary trauma

(Munroe, 1994) suggests that therapists will usually not be aware of when they are being drawn into re-enactments and secondarily traumatized. Stadler (1990), studying burnout, writes that denial is common in relation to the topic of impaired counselors, and attributes this in part to the myth that training and experience in a mental health professional offers immunity from emotional problems. This suggests that even if therapists know about their secondary reactions they may deny them. In primary trauma many authors have identified the violated sense of invulnerability as a salient factor, but in secondary trauma it may be the myth of professional invulnerability that is significant.

The image of the objective observer and expert, which seems to operate in our professional schema, may lead professionals to believe that they should not have any reactions to their trauma clients. Those who do express their feelings or talk about their reactions may be seen as unprofessional by those who would prefer to deny their own vulnerability. They might be told to seek therapy or get more thorough training. Therapists might be told, as their clients frequently are, to forget about it and get on with their lives. Therapists might also be told that a particular response is a countertransference issue due to some pre-existing condition unrelated to trauma, as their clients are sometimes told. This of course will be of no help to the distressed therapist, not to mention what kind of model it projects for clients. The empirical data on experience and education provides insufficient evidence as to whether these prevent the effects of secondary trauma. In the absence of clear data, and at the risk of allowing "significantly impaired" therapists to practice, it does not seem ethically justifiable to assume any therapist has immunity from secondary effects.

If we begin, however, to search for the point at which a therapist becomes significantly impaired, we will have missed the point. The APA codes require action on impairment only when "there may have been an ethical violation" (p. 1611), but this is too late in the process. The burnout and impairment litera-

ture are examples of how efforts to "find the damaged ones" leads to a sort of frenzied searching which will only promote further denial. If we attach the impaired label to therapists who are being secondarily traumatized we end up blaming the victims. On the other hand, if we recognize secondary effects as a normal response to the abnormal occupation of being a trauma therapist, we can begin a dialogue. There is also a tendency to identify new therapists or those who have trauma histories as more susceptible to secondary effects. The literature does not support these ideas so far. Munroe (1991) did not find a difference in secondary effects between therapists who reported a combat history and those who did not. Chrestman (1994) found that trauma survivor therapists show more effects of being traumatized, but it is not clear that these have anything to do with their work as therapists. It could be argued that therapists with a trauma history might be better prepared to deal with secondary effects. This is an old argument about cumulative or inoculative effects which remains unresolved. From an ethical viewpoint, it appears prudent to assume that all therapists are susceptible, and that all therapists should address these issues on a regular basis. This would provide a good model for less experienced therapists even if more seasoned professionals had identified ways to cope effectively.

If all therapists are vulnerable, and both personal and professional interests lead to denial of this vulnerability, this may have a profound impact on trauma therapy. How will therapists be able to determine when their own normal and legitimate responses get to the point of interfering with therapy? If it is the case that the therapist being affected is unlikely to recognize this, then we must ask whether it is ethical to conduct traditional one-on-one psychotherapy with trauma clients. Perhaps individual therapy should only be conducted when a clear support team that is trained to monitor secondary responses is involved. If therapist responses are parallel to those of their clients, these responses can be used as clinical data to enhance the ther-

apy process for clients and buffer the negative effects for therapists (Munroe, Shay, Fisher, Makary, Rapperport, & Zimering, 1995).

Welfare of the Therapist

Conspicuously absent from the ethical codes is the welfare of the therapist. Psychologists are instructed to avoid harm "to patients, clients, colleagues, students, research participants, or others with whom they work" (p. 1601). If in fact we do not include ourselves, we are once again providing a damaging model to trauma clients. Survivors of traumas caused by people have been abused by those who deny the importance of the victims' welfare. They often are taught to ignore their own welfare and to sacrifice themselves to the needs of the abusers. When therapists fail to practice adequate self care they reinforce the idea that one should allow oneself to be abused. Such a model may invalidate the help a therapist can offer. The therapist who fails to take lunch breaks, doesn't go on vacations, and works too much overtime to help clients, may in fact be damaging them. Trauma survivors have often been betrayed by words, and if so, they may be much more interested in the actions and behaviors of therapists. They are tuned to what we model and whether we practice what we preach. If we are modeling for our clients, then therapists have an ethical duty to actively demonstrate good self care.

Competence

Secondary trauma in therapists is a fairly new concept in the trauma field and data is only beginning to emerge. The literature has not yet empirically demonstrated any effective means of prevention. Nonetheless, the codes states "in those areas in which recognized professional standards do not yet exist, psychologists exercise careful judgment and take appropriate pre-

cautions to protect the welfare of those with whom they work" (p. 1599). Some authors have proposed what some of these precautions might be (Catherall, 1995; McCann & Pearlman, 1990; Pearlman and Saakvitne, 1995; Munroe, Shay, Fisher, Makary, Rapperport, & Zimering, in 1995), but many more need to be developed.

Ethical Guideline Proposal

As a starting point, the following proposals are offered to spur such development: (a) trauma therapists should acknowledge the effects of secondary trauma on themselves and their colleagues and take regular, ongoing actions to insure the welfare of professionals and to preserve their ability to deliver quality services; (b) trauma therapists should not work alone but instead should seek out or create arrangements in which they have regular and open input from other professionals regarding the effects of secondary trauma and its impact on the services they deliver; and (c) trauma therapists should recognize an ethical duty to self care.

Conclusions

Secondary trauma challenges the field to expand our concepts of ethical practice. Our ability to act ethically in response to this challenge can potentially enhance the wellbeing of both therapists and clients. Failure to do so will diminish us all. The ethical duty to respond will challenge professional organizations, educational institutions, administrators, supervisors, and practitioners, but ultimately each individual will have to confront him- or herself on a regular basis to insure proper ethical behavior. It is hoped that this article will motivate readers to actively challenge themselves with the questions raised.

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